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January, 1952

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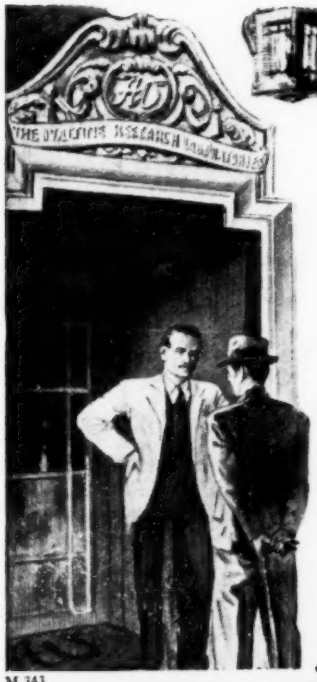

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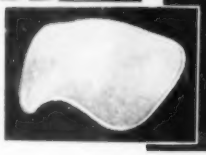

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ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

Vol. LVI JANUARY, 1952 No. 1

"ODDLY ENOUGH"

(With apologies to Paul Jennings)

Who says that there's no magic in London? Well, of course, if you mean strange numinous presences, I suppose you must be right There are no nymphs in St. John's Wood, nor zephyrs up on the Heath, and who has seen Pan in Arnos Grove? But folk must be dull, dull indeed if they can find nothing lightly fantastical as they travel about London, and after all it is only whilst we travel that we can spare a moment to let thoughts wander from the narrow path of our busy lives, to lay down the blinkers and strait-jackets of convention, and exercise out atrophied imaginations.

Carried down into the netherworld of the "Underground" by an ever-moving staircase, endless advertisements of female accoutrements float before our unseeing eyes. There can be no situation so anaesthetic to the ordinary processes of the mind as being on a "down" escalator. Thoughts become less and less practical, more and more speculative. We step off at the bottom in an abstraction.

Look around. Isn't the whole place filled with mystery? Where do all those people disappear to down "No Exits"? Try to follow one of them and he vanishes leaving you in a tunnel full of Tube-smelling draught. Pursue him and you end up in that banana shaped chamber one can sometimes see lit up between the moving stairs. Tell me, why do only half the trains dare to stop at Mornington Crescent? And, according to what natural law do they clip your ticket on some days and not on others. Answer that!

Borne away into darkness like Lohengrin in his swan-drawn craft, bound for the Holy Grail, we find ourselves arbitrarily paired into anonymous couples, uneasily aware of one another's presences, undergoing a curious chair-like motion some hundreds of feet below the earth's surface. This is the time for meditation. Look at those close-lipped women, freed for brief hours from their bed-sitting rooms. Regard the bowler-hatted, horn-rimmed, men returning to the fetters of their family. Contemplate that gaunt and lifeless figure hanging from his leather noose, or better by far, study the *Tube map*.

The map as a whole presents an attractive design, but now take it to bits, look at the modern streamlined no-nonsense Bakerloo, and the rambling, vague, ample, wandering District (alias Circle and Metropolitan), as though it couldn't make up its mind which to be, or where to go, or, indeed, where to stop. Personally, I like the Central Line the most, because it calls at both Gants Hill and Shepherds Bush. Gants Hill seems related to Gads Hill and surely must be peopled by fantastical Falstaffian characters marching at the head of a disarrayed army. At the other end of this line, rich with such mellifluous names as Snaresbrook, Theydon Bois, Blake Hall, Ongar and Fairlop, is Shepherds Bush where some herd boy plays a country air upon his reed pipe (vaguely reminiscent of that bright-young-thing practising on that wretched plastic recorder in the flat below) Then there are other stations of character: Wapping—here is the sound of the slap of greasy tides against the stern of Thames wherries, low angry voices and paddles splashing in the river fog. Ashore the great gates of eerie warehouses are padlocked across sweaty glistening cobbled alleyways, and in the dark you can hear the trundling of a handcart past all-night coffee stalls. Hendon, here are terracotta birdbaths and

1924-ish parties, women in cloche-hats and young men in flying helmets and privately-owned biplanes. On Sunday afternoons at Tooting Bec large men kick soggy footballs amongst the endless allotments and rumbling, gibbering, squeaking trams. Ravenscourt Park is but a polite name for some Castle Dracula, where dark vampires clamber up and down the creeper-covered trelliswork. Mill Hill, you see, is on that Northern branchline, which was specially extended by the private petition of the rich Mill owner in prosperous 1850. But things have changed, and there is little life now amongst the black brick sidings, the empty waiting rooms with their advertisements for cheap rates to Pontypool peeling from the damp walls behind the rusting weighing scales. The Old Mill no longer turns and the track is over-grown with ragwort and wild columbine. Dollis Hill was a name I had always cherished upon the Tube map. The High Street curved up the Hill between the old stone houses, corn chandlers, furriers and sweet shops, where grey-haired sisters weigh out bullseyes from tall glass jars, and the Post Office sells staples and rabbit wires wrapped up in a copy of the *Farmer's Weekly*. To me, it was the kind of place where you are met at the station, and rattle home in a dogcart to a fire-lit tea of toasted scones, butter and ample jam. At least, so I thought, until I visited my friend, Barleycorn, last week. I stood on Dollis Hill Station in the drizzle at the doldrum-hour of nine o'clock, surrounded by the fish-and-chip bars and great panel-beating works of North London. At Dollis Hill I learnt what disillusion was.

Now groaning and swaying one of those curiously fashioned Waygood-Otis lifts with four sides and no angle a right-angle, we rise to ground level again. The gates crash open on whichever side we happen not to be standing. We step into reality. A bustling shoddy road, where it is always Saturday afternoon and the crowds shuffle past dismal shops of chromium kettles, lampshades and dreary pink underwear. First left, then right, and your latchkey turns in the lock.

* * *

You get so little time to meditate, be it on Tube Maps or less important things, so make the most of it!

In this issue of the *Journal*, most of the articles focus our attention upon some of the literary facts of the doctor's life. We are honoured by an article on the preparation of material for the medical press by an old Bart.'s man, Dr. Hugh Clegg, the editor of the *B.M.J.* Sir Ernest Gowers in his article on "Jargon" carries his battle against those who misuse our language right into the medical camp. We are very pleased to print another article on four Bart.'s men, who did much for *Punch* in its early days, by Philip Gosse, one of our most distinguished old students, who has been contributing to the *Journal* for over fifty years.

A Lost Pharmacopaeia

In 1614 an "apothecaries shop" was first erected in the hospital; brass mortars and weights were provided, as well as herbs and drugs. Since then frequent entries in the hospital records refer to it and its modern successor, the Pharmaceutical Department. It had of course, records of its own, and some are kept in the Archives Room. We have three account books, and a few pharmacopaeias, the earliest of which is dated 1768. There must have been more, and we would be very grateful for any information whatsoever about them. It is known that some of them were seen in the hospital not long ago; but their present whereabouts are a complete mystery.

The Royal Hospital of St. Bartholomew

A short history of the hospital written by our archivist, Dr. Gweneth Whitteridge, has just been published. The text is new, and corrects several errors in an earlier edition. It is excellently illustrated and well presented, and forms as complete an introduction to the history of the hospital as one could wish for. *The Royal Hospital of Saint Bartholomew* may be bought from the Librarian. Its price—one and sixpence.

Art Amongst the Doctors

As a correspondent points out (see page 299), the attitude of the Arts Council is not only strange and biased against some students, it is also short-sighted. In these days the medical student is no better provided for by grants than is the Art student, and it seems unfair that we should not be granted similar privileges in visiting Art exhibitions.

The excellent attitude of the foreigner in preferring one original painting by an unknown artist, to a number of familiar prints of the "Old Masters" can hardly be called popular in this country. It is high time that the future potential private patrons of the Arts, for that is what we are, were encouraged to interest themselves in modern art from abroad, and the work of our own artists, by visiting these exhibitions. A reduction in the entrance fee would certainly be an inducement.

George Medallist

By kind permission of the B.M.J.

The *London Gazette* has announced the award of the George Medal to Surgeon Lieutenant James G. H. Shepherd. On April 27th this year, a lighter was being loaded with ammunition from the Naval Auxiliary vessel *Bedenham*, in His Majesty's Dockyard, Gibraltar, when a minor explosion occurred. Immediately, Shepherd went to the wharf to search for casualties. After he had rescued a badly burned man from the water, a second and much larger explosion occurred, cutting the *Bedenham* in two and sinking her. Despite being only fifteen yards away he fortunately escaped unharmed and at once began to administer first-aid to the seriously injured on the wharf. The citation reads:

> "He showed a complete disregard for his own safety and his single-minded determination to do all within his power to seek out the casualties, care for them, and relieve their pain was worthy of the highest praise."

Shepherd came to St. Bartholomew's Hospital in 1943. He qualified in 1948, and later volunteered for the Navy. We send him our congratulations.

Bart.'s THE Rowing College

We congratulate the Boat Club, who have once again won the United Hospitals Challenge Cup. This was by no means the only Bart.'s success at the United Hospitals Regatta, where we also carried off both the Junior Eight and the Junior Four trophies. John Currie, who stroked the first eight for the fourth year running, is the first Houseman to row for Bart.'s for many years—we hope that his precedent will be followed in the years to come. The stern four of the second eight deserve special mention for winning the Junior Fours final almost immediately after a neck-and-neck race in the eight. Few people at the Hospital, to judge by the small number of supporters, realise that the Bart.'s Boat Club very often wins its races.

A Local Shrine for Troubled Wives

The life of St. Uncumber or St. Wilgeforte is of considerable interest. She is said to have been born one of nontuplets. Later in life, despite her wishes and a vow of perpetual celibacy, her father arranged a marriage for her to the King of Sicily. She prayed hard and long, and divine help came in a curious form.—an adreno-genital syndrome—and she grew a beard and moustache. As soon as the King of Sicily saw this strange transformation, he cancelled the wedding. The bride's father was so angry that he had his daughter crucified. Wives afflicted with troublesome husbands may invoke her by presenting a handful of oats. There is such a shrine in St. Paul's. I have been asked to add that the shrine is no longer in action

Cambridge Sherry Party

The Sherry Party, held by the hospital Cambridge Graduates' Club, was the first to be attended by lady guests and members. The Library was in festive mood, with an interesting exhibition of prints in the gallery, and the librarian's desk transformed into a bar. Dr. A. C. Roxburgh must be congratulated as President of the Club, for giving us what we shall hope in the future to regard as the first of many happy occasions.

ENGAGEMENT

The engagement is announced between Ronald Cathcart, son of Dr. and Mrs. A. C. Roxburgh, of 5, Redington Road, and 121, Harley Street and Miss Angela M. E. Grylls.

MARRIAGES

The marriage took place between Miss Nancy Heywood and Gilles Kaan at St. Margaret Mary and the Sacred Heart, Fullwell, on Saturday, November 17th.

The marriage took place between Miss Kathleen M. Herbert and Dirk J. Boet, at Emmanuel Church, Southport, on November 24th.

SOME NOTES ON PREPARING MEDICAL PAPERS

By HUGH CLEGG

If an author does not express himself clearly, does not know how to use punctuation marks, mis-spells words, gives inaccurate references styled according to no plan, produces an untidy-looking typescript, spaced singly and with little or no margin at teh left of the page, then any editor will conclude that the author's mind, and so his work, resembles his product. If one has to read, as I do, hundreds of manuscripts a year then one will inevitably look more favourably at those which cost one the least effort. It is true that a pearl is concealed in a most unlikely place, but it is unwise to expect an editor to spend much of his time prizing open shells on the off-chance of finding something valuable inside.

Science, to repeat the well-worn cliché, is measurement, and now that medicine is becoming more scientific measurement is something that must be given its full value. Many painstaking investigations have failed for the simple reason that the investigator has neglected measurement. Medical statistics is an indispensable tool in medical research, even though such research may be of a relatively simple nature such as the tabulation of certain facts in a collection of cases. If the would-be author finds, as I do, medical statistics a bit of a headache, then he would at least be wise to seek the advice of those competent to give it. Too often a paper will come into an editorial office with numerous tables from which the author has drawn conclusions that do not stand up to simple statistical analysis. I remember one conscientious author who had spent nearly two years collecting facts on different methods of treating a certain disease, and with his paper there were tables from which he claimed to draw firm conclusions. Most unfortunately the conclusions were unrelated to the facts. When this was pointed out to him, he, far from being grateful, stormed up and down my office muttering such sacred words as "clinical intuition." In fact, he was so worked up that when he sought another interview he asked to bring his mother with him, which did not seem to me to be relevant to the case. This man could have saved himself a lot of trouble and disappointment if he had planned his investigation with the aid of a medical statistician. The statistician comes in at the beginning, not at the end. It is the custom of more and more editors of medical journals to send articles which have numerical data to statistical referees, and they tend to be ruthlessly objective in their assessment of what they are asked to judge.

In his Notes on the *Preparation of Papers for Publication*, the late G. H. F. Nuttall said there were certain golden rules which every author should follow: he should "(a) try to imagine himself in his reader's place; (b) proceed on a definite plan; (c) study compression; (d) revise his manuscript carefully; (e) read and correct his proof conscientiously." One might add to these: (f) check all references; (g) make sure that the totals in tables add up correctly (they hardly ever do); (h) end the paper with a full and intelligent summary.

Apart from the present enormous costs of production, with the price of paper more than 200 per cent. what it was at the beginning of 1950, how one wishes authors would take more notice of Dr. Nuttall's golden rule "to study compression." Learning to write is like learning to ride a bicycle; one cannot help falling off to begin with. Some people have a natural facility, but most have to learn by trial and error. There are plenty of good guides. One has the impression that the young author thinks that if he uses long words and involved sentences he will pass for being a member of a learned profession. So many sentences are written rather like this: "It is my considered opinion that all the accumulated facts go to show that there might be in this disease some unknown and imponderable factor, the discovery of which will illuminate this highly complicated problem." This could be put more succinctly thus: "What evidence there is suggests an unknown factor as the basis of the problem of this disease." Then there is the abominable use of medical jargon. "Case No. 40 died of shock." Cases do not die, but patients do. "This patient had an unusual pathology." Pathology is defined in a well-known dictionary as "that branch of medicine which treats of the essential nature of disease, especially of the structural and functional changes caused by disease." How can a

patient, or even a case, have this? Another abomination: "He was a carcinoma stomach." Then there is that word which, even for editors, has a deadly fascination—'marked.' "He had a marked murmur." "She had a markedly enlarged spleen." "She had a marked growth of hair on her upper lip." This word "marked" really means nothing at all. One assumes that the "marked murmur" was a loud murmur, that the "growth of hair" was profuse; and why not be accurate and state that the spleen was so many inches or centimetres below the lower costal margin? If only authors would remember that most sentences have a subject, a verb, and an object; that the active voice is more effective than the passive; that short words ram home the point more clearly than do long words; that there is no merit in a long sentence; that adjectives and adverbs should be used sparingly and only when they add to the meaning, they would save themselves and their readers a lot of trouble. Medical writers often like to talk about a "meticulous" examination. As Fowler says in *Modern English Usage*: "What is the strange charm that makes this wicked word irresistible to the British journalist?" One of my own fads is the wrong placing of the word "only" and I was disappointed to see Sir Ernest Gowers, in his recent *A.B.C.*, excuse this on the grounds that so many people do it. "I only met Jones yesterday," someone says. If you turn this sentence round you will see it makes nonsense. "Yesterday I only met Jones"—a day, I word "only" should come before the word should say, not well spent. Obviously the it qualifies—yesterday.

So I would say at the beginning of these few notes that anyone sending in an article for publication should have it typed clearly on one side of quarto paper, with double spacing and a left-hand margin of 1½in. to 2in., so that editorial corrections can be easily made. Many authors, incidentally, forget to number their sheets of typescript. Tables, charts, and graphs should be on separate sheets of paper, and it should be indicated in the text where these should appear. References should also be on a separate sheet of paper, and they should be styled according to the custom of the periodical in which the author is seeking publication.

Many journals now adopt what is wrongly called the Harvard system of giving references. The references are arranged alphabetically. The author's name comes first, followed by his initials; then comes the date of the publication in parentheses, then the title of the book or periodical in italics, and, lastly, the volume numbers in bold Arabic numerals and the first page number in ordinary Arabic numerals. In some journals the first and last page number of an article are given: this is useful because it does give some idea of its length. The reference in the text is given thus: "Some authors (Dejean, 1947; Laroche, 1947b) have reported Addison's disease with rheumatic joint lesions . . ."; or "Selye (1949) noted that rats treated with large doses . . ." This system replaces the older one of giving references numerically. This is not the place to argue for and against these two methods, but the so-called Harvard method, which is adopted in the *British Medical Journal*, is advocated by the Royal Society.

There are one or two other points about the preparation of a manuscript that might be mentioned here. A long paper should be broken up by cross headings that indicate the main divisions of the paper. All except very short articles should have a concise summary of the principal findings and deductions from them. Incomplete or inadequate summaries are the rule rather than the exception, and even experienced authors seem at times to be unaware of the value of a good summary. Most readers of scientific periodicals probably read the summary first, and if their interest is stimulated by this will go on to read the full article. Not only that, but a good summary is invaluable to those conscientious and hard-pressed workers who prepare abstracts for the various abstracting journals and sections of journals.

Graphs should be drawn in black ink on stout white paper or Bristol board, and letters and figures should be written lightly in pencil, not in ink. Graphs usually have to be reduced in size for reproduction, and those responsible for this have to put in letters and figures of such a size as will be legible after reproduction. When illustrations have to be reproduced by the half-tone process authors should send X-ray films rather than prints. Photographs should be on glossy paper and only slightly larger than the size of reproduction in the journal in which publication is sought. What the customary sizes are can be discovered by looking at a few copies of the journal. Pictures to be reproduced by the half-tone process suffer if the

reduction has to be too great. Photomicrographs, too, must be printed on glossy paper and the legends to these should be typed on a separate sheet of paper. Authors would help editors a lot if they were to indicate what parts of an X-ray film or of a photomicrograph should be especially brought out.

This is all rather obvious stuff about preparing a paper, and much more could be, and has been, written about it. Yet many authors tend to overlook the obvious, and in doing so unwittingly exasperate those who have to handle the numerous manuscripts, bad, good, and indifferent, which day by day come into an editorial office.

But before beginning to write a paper it is important that an author should decide whether or not he has something really worth saying. In these days of merit awards and job-hunting in the face of intense competition, publication of articles in a medical journal is more than ever the stock-in-trade of those anxious to get on in the world of medicine. The aspirant to higher things, one would guess from what one reads, searches desperately for a subject on which to write. Either he collects cases in the hope that something will turn up from a mass of ill-assembled facts, or he will start an investigation with the same pious hope. By not exploring the ground in advance many authors fail to achieve their aim of publication. In printing, an important operation is known as the "make-ready," and a good printer will spend any amount of trouble and time in attending to his machines, looking to the ink ducts, and making quite sure that the right amount of backing is given to illustrations, and so on and so forth. If only those who wanted to have their words printed would take the same trouble they would get much better results. Anyone with a bright idea should, therefore, make quite sure that the same idea has not occurred to someone else. This he can do by reading the literature and by consulting those more experienced than himself. If he finds that the idea is original—within the wide limits of originality—then before starting on an investigation he should spend a long time in planning it.

These notes, I fear, are rather disconnected and written in haste. With more time I might have written something shorter. One last word I might add. When an author has finished his first draft he should persuade one or two brutally candid friends to criticize it, because it is impossible to spot one's own mistakes.

JARGON

By SIR ERNEST GOWERS, G.B.E., K.C.B.

I deprecate the common use of the word *jargon* as a term of abuse to be applied to any writing one thinks inferior to one's own. Its original meaning is more precise, and it is bad for a language when the sharp edges of its words are blunted. I should like to see *jargon* confined in meaning to technical terms peculiar to particular pursuits—whether arts or sciences, professions or trades, games or sports. It should be regarded as a neutral word, not necessarily a disparaging one. Up to a point jargon is harmless, and indeed useful and necessary. A word may have to be invented to denote some new thing or concept for which there is not yet any word in the language. What would golfers do if there were no golfing jargon, and a stymie had to be described by some elaborate periphrasis? But the origin of jargon-words is not always so blameless. The thing or concept may really not be new. There may be already a word for it, but a jargon-word is invented so as to create an illusion of newness. This questionable practice is becoming sadly prevalent. I recently read an article in which an eminent man of letters looked forward apprehensively to the day when increasing specialisation and an increasing use of jargon-vocabularies will leave us with no common vocabulary with which to convey our thoughts to one another, so that babel will overtake the English language.

I think the chief sinners are the newer sciences, especially psychology and psychiatry and sociology and, to a less extent, economics. These are no doubt entitled to their jargons, within reason. I do not myself pretend to know just what the *id* is, and I am not greatly wiser when I consult my most modern dictionary, and find the definition to be "the sum total of the instinctive forces in an individual." But I am ready to believe that no existing word has quite the same

meaning, and a new one was necessary. And I am ready to concede that, given the need for a jargon-word, a less pretentious one could hardly have been found: never can so much meaning have been packed into so small a space since the sentence "Thy kingdom is divided and given to the Medes and Persians" was compressed into the word *upharsin*. But these praiseworthy attempts to enrich the language are not the whole of the story. Our mother-tongue is at the same time being debased by an itch to give new names to things that are not really new. *Circumstances* must be called *environmental factors; groups* must be *brackets; living* is swallowed up by *viable* and *combine* by *synthesise;* familiar words like *character* and *behaviour* will no longer go by themselves: they must be put into double harness with *structure, pattern* and the like. I have known a writer suffering from this itch to refer to what old-fashioned people would call *fornication* as "bilateral erotic experiment outside marriage," and another to tell his readers that:

> "Reserves which are occupied in continuous uni-directional adjustment of a disorder are no longer available in the ever-varying interplay of organism and environment in the spontaneity of mutual synthesis."

What causes this itch? Do those who study these subjects feel that a science cannot really be a science unless it has a jargon of its own; it must discover new things, and unless new words are found for those discoveries no one will believe they are really new? Or is Mr. Ivor Brown's explanation the right one? He says that jargon is a kind of uniform:

> "The English love to wear ritual clothing and so cherish a ritual verbiage too. The barrister will not put away his wig: the parson has his dog-collar: the official has his pin stripe trousers. There is a gobbledygook of the Law, of Theology, of Finance, of Sport, of Criticism. The users will no more drop the lingo than they will abandon the insignia and haberdashery of their professions."

Doctors are exceptions to this rule of sartorial conservatism. They have abandoned the top-hat and frock-coat that were until recently the insignia and haberdashery of their profession. I wish I could add that, with their ritual clothing, they are discarding their ritual verbiage; but I suspect the contrary to be the truth: that losing the one is making them rely the more on the other. They have of course a large and well-established vocabulary of highly respectable jargon. *Diagnosis* and *prognosis* are indispensable jargon-words, because there are no words in general use that have quite the same meaning. For *treatment* the good English word serves well enough, and one might have expected the same to be true of *causation*. But perhaps *aetiology* does not mean quite the same as *causation*: anyway, since *aetiology* has been established for at least three hundred years it cannot be cited as evidence of the contemporary growth of jargon. But the same indulgence cannot be extended to the habit of speaking of an *aetiological factor* instead of a *cause*, and I can think of no explanation other than the ritualistic one for the disappearance recently of the word *walking*, and its supersession by *ambulant* and *ambulation*. The following comparison is significant.

> "The patient can walk with assistance, and should be encouraged to do so." (From a lecture delivered in 1886).
>
> "There is no need for bed all the time; the patient should be advised to take intermittent ambulation." (From an article written in 1951).

It may no doubt be argued that *ambulation* does not mean quite the same as *walking*, but that does not justify its throwing *walking* out of business altogether.

I have elsewhere commented on the queer fact that the specialist who in my boyhood was called a *mad-doctor* has since passed through the chrysalis of *alienist* into the butterfly of *psychiatrist*. Surely, I said to myself, this cannot be the same person; I must be doing the profession an injustice. So I consulted that unimpeachable authority, the Oxford English Dictionary. These are the definitions I found there:

> *Mad-doctor*: a physician who treats mental diseases, an alienist.
>
> *Alienist*: one who treats mental diseases.
>
> *Psychiatrist*: one who treats mental diseases, an alienist.

It would appear then that the only difference is that the mad-doctor has to be qualified and the alienist and psychiatrist need not be. So I was disappointed, and could only conclude that this succession of names represented new issues of ritual clothing made from time to time to replace what had become old-fashioned or worn-out. Perhaps euphemism had something to do with it. *Mad-doctor* is not a pretty designation. I remember it used to be given to us at school as the stock example of what grammarians call the "transferred epithet." But that may have seemed to the mad-doctors themselves

inadequate protection against misunderstanding, and they cannot be blamed for wanting a title free from all ambiguity.

In deprecating an excess of jargon, we must not fall into the error of being undiscriminating in our opposition to it. Philologists in this country are resistant people: they do not take kindly to new words, especially of American origin. Some of these would-be immigrants are indeed showy impostors seeking only to take over the jobs of honest hard-working English words. Any attempt to refuse admission to words of that sort deserves the support of all of us. But a word ought not to be rejected merely because it is new, even though it may come from America. The language is not static; it is changing all the time, and America has greatly enriched it in the past. New words applying for an entry-permit ought to be asked to produce their credentials by showing both that they fill a gap and that they are not aesthetically or etymologically abominable. To *hospitalise* is not a pretty word, but we cannot deny its claim to say what otherwise cannot be said in one word, and I think it may have come to stay, whether we like it or not. To *special* seems to have established itself in the nursing service jargon, and we must admit its convenience. But it would be well if everyone tempted to coin or adopt a new piece of jargon approached the question in the same spirit as Dr. Julian Huxley, who said in a recent broadcast:

> "We need a term for the sum of these continuities through the whole of evolutionary time, and I prefer to take over a familiar word like *progress* instead of coining a special piece of esoteric jargon."

No doctor of middle-age or upwards who was educated at Cambridge University has any excuse for excessive addiction to jargon, for he must have come under the influence of Sir Clifford Allbutt, who attacked it unceasingly. Allbutt, who was Regius Professor of Physic from 1893 to his death in 1925, was a remarkable man. Tall, handsome, suave and distinguished, he was the sort of person that Buffon must have had in mind when he made his famous remark about the style being the man. He hated sloppy thinking and woolly writing, and found too much of both in the eighty-odd theses for the degree of M.B. and the thirty-odd for the degree of M.D. that he tells us he had to read every year. "The prevailing defect of these compositions," he said, "is not mere inelegance: it is such as to perplex, and even to travesty or to hide the author's meaning." So he wrote a little book for the benefit of medical students which he called *Notes on the Composition of Scientific Papers* (*Macmillan*). "It is far from my intention," he wrote, "in these simple instructions to advocate a manner of writing in which pith and character are lost in polish and affected elegance; indeed my purpose is literary only so far as to insist on the qualities of clearness, precision and definition." Thus there was published nearly fifty years ago for the special benefit of budding doctors a book which anticipated almost all that is useful to the ordinary writer in what Fowler and others have since said about clarity and simplicity of expression. It would be a good thing for the medical profession and indeed for every profession if a thorough knowledge of this book was made a qualification for entry into it. As Allbutt says:

> "By disorderly and hazy writing we fall into worse things than muddle: we blunt the probity of our minds; we slur over difficulties and cover up ignorances . . . Force, lucidity, unity, simplicity, economy of expression, are virtues which we may all obtain; originality will be as God pleases."

DEATHS

GERARD OLIVER HOLMES.

We announce with much regret the death, following a motor-cycle accident, of Gerard Oliver Holmes. He had come to Bart's from Rugby School and Balliol College, Oxford, in April. Apart from his work, he was keenly interested in other activities, a 'cellist and musician, a practical photographer, and naturalist. We send our sincere sympathy to his parents at Quorn, Leicestershire, and to his many friends.

The death was announced on November 27th of Clement Alexander Francis, M.A., M.B., B.Ch.(Camb.), of 75, Wimpole Street. He qualified from St. Bartholomew's Hospital in 1925.

The sudden death was announced on October 25, of Henry David Kelf, M.R.C.S., L.R.C.P., D.P.H., of 214, Sandbanks Road, Parkstone, Dorset, at the age of 79. He qualified from St. Bartholomew's Hospital in 1919.

FOUR HUMEROUS WRITERS FROM BARTS

By PHILIP GOSSE

Our *Journal* has a long and distinguished record of some sixty years, but we cannot but regret it was not founded some fifty years earlier, say about the year 1840. Had this been so, it would no doubt have had as editor and contributors a most remarkable coterie of literary-minded students, who took a leading part in the birth and early years of that most venerable of all humorous periodicals, *Punch*. It was an extraordinary chance that these men should all have been studying medicine at Bart.'s at the same time, all four of whom were to become famous in their day, not as doctors but as writers or artists on the staff of *Punch*.

"WHAT? YOU YOUNG YANKEE-NOODLE, STRIKE YOUR OWN FATHER!".

An example of the Political Cartoons of John Leech✠ By kind permission of the proprietors of *Punch*.

It may interest some of the present generation of Bart.'s men—and women—to be reminded of them for they brought no little glory to our Hospital. The four were, John Leech, Albert Smith, Percival Leigh and Gilbert à Becket. There seems to be some doubt, however, about the last, for although it is known he shared "digs" with John Leech, it is not certain if he ever studied medicine before reading for the Bar. Taking them in the above order, we will begin with *John Leech*, the humorous artist who was born in London in 1817, his father being the proprietor of the London Coffee House in Ludgate Hill. At the early age of seven little John was sent as a boarder to the Charterhouse, close to the Hospital, much to the distress of his devoted mother, who, secretly, hired a room with a window overlooking the playground so that she could watch her son at play. After nine undistinguished years at *Grey Friars*, at the age of sixteen John Leech began to study medicine at Bart.'s, where he met as fellow students, Smith, Leigh and à Beckett. His career at the Hospital was only notable for his proficiency in making anatomical drawings which were greatly admired by Mr. Edward Stanley, F.R.S., who held the post of lecturer in anatomy as well as being a full surgeon and was then the most celebrated clinical teacher in London*.

It would be most interesting if any of Leech's anatomical drawings should be found to exist†. His father had intended placing his son with Sir George Ballingall

✠ Published one hundred years ago at a time when there was a small difference of opinion over the State of Oregon.

* Alfred Willetts' account of Edward Stanley in the *Journal*: 1894. 1. 147.

† There are none preserved in either the library or the museum.—*Editor.*

the distinguished Edinburgh surgeon, but finding he could not afford the high premium for this, John was apprenticed to a medical man of quite a different pattern, an apothecary, Mr. Whittle of Hoxton "who combined a great deal of pigeon fancying and the kind of athletics in favour with strong men at fairs." Mr. Whittle's love of animals was not confined to pigeons, for he kept rabbits and guinea pigs and ferrets as well. The area of his house was filled with poultry; at every window hung cages of singing birds; while the whole of the roof was converted into an enormous trap for catching his neighbours' pigeons. Here, on fine days, Mr. Whittle would sit for hours on end, smoking his pipe and sipping brandy and water, while he watched his neighbour's pigeons enter his trap. In due course it dawned upon Mr. Whittle that medicine was not his true vocation so he married the widow of a local publican and took an active part in dispensing drinks from behind the bar.

By this time Leech and his fellow apprentices had decided to look for other teachers, and John was apprenticed to a Dr. John Cockle, son of the inventor of the famous Cockle's Pill. Perhaps a contemporary description of Whittle may not be out of place. He is described by one who knew him as "an extraordinary person for a medical practitioner. At the age of 38, he was of Herculean build, except for his short legs; broken nose—the result of some hospital skirmish when a student—and a pair of luxuriant black whiskers which met under his chin."

But Leech too began to doubt if he was cut out for a doctor, and decided to devote himself entirely to drawing, so when his father failed in business—coffeehouses were being killed by the increase in clubs—he finally abandoned medicine for art. In August, 1841, at the age of 24 he became a regular contributor to *Punch* until his death at the age of 47 from *angina pectoris* or "breast pang," brought on, it was thought, by a "disturbance of his nervous system caused by the continual visitation of street-bands and organ grinders," but, according to his friend Dr. John Brown in his *Horae Subsecivae*, by the strain of fox hunting, Leech being an indefatigable follower of the *Puckeridge and the Pytchley*.

Our next Bart's student who became a member of the staff of *Punch* was Percival Leigh, who continued a life-long contributor under the pen name of *Prendergast*. He had a brilliant career at the hospital:— Sir James Paget declared he was the best man of his year, and "admirable in diagnosis." He took the L.S.A. in 1834 and the M.C.S. a year later when he began to practice, but soon abandoned medicine for literature. On the foundation of *Punch* in 1841, Leigh became a member of the staff and continued to write for it until his death in 1889, at the age of 76. All through his life he was known to his friends, and he had many, as the *Professor*. Leigh was an enthusiastic and accomplished amateur actor and often appeared with Dickens, Leech and Douglas Jerrold of *Punch*. Leigh published several humorous books, the most popular being *Ye Manners and Customs of Ye Englyshe*. Most of his books were illustrated by Leech. Quite another type of man to the friendly easy-going Percival Leigh was his one-time fellow student and fellow writer to *Punch*, Albert Smith. Son of Richard Smith, a surgeon practising at Chertsey in Surrey, he was educated at Merchant Taylors and at the early age of 15 went to the Middlesex Hospital before going on to Bart.'s, where he shared lodgings with John Leech and Gilbert à Beckett. In 1836, at the age of 22 he became a licenciate of the Society of Apothecaries, and a member of the College of Surgeons, and then joined his father in practice. In January, 1841, he turned author with the first of a series of articles entitled *The Confessions of Jasper Buddle, A Dissecting Room Porter*. In the same year he settled in Percy Street, off the Tottenham Court Road, as a surgeon-dentist; he had by now become a regular contributor to the newly-founded weekly *Punch*.

In the same year appeared his *Physiology of the Medical Student*, a boisterous but still amusing description of the daily and nightly life in the eighteen forties of a Bart.'s medical student. In those days, before the invention of organised sports, there was a lecture in physiology at two on Saturday afternoons. First-year students went with the lecturer in Botany for rambles in the wilds of Wandsworth and Wimbledon and on the hills of Highgate and Hampstead. The mantelpiece in the dissecting room was always crowded by beer mugs, and the dissecting room porter was ever ready to go round to the market to fetch more. Also the students used to broil sprats and red

herrings in the coal shovel over the roaring fire — whenever the demonstrators were called away to attend a private patient.

The next year there appeared the most popular of all his novels, *The Adventures of Mr. Ledbury*. From this time onwards Smith was continually turning out a regular stream of verse, epigrams, jokelets and articles on current events, until he quarrelled with Mark Lemon, part-founder and first editor of *Punch*. He already had quarrelled with most of his fellow contributors, almost all, indeed, but the good-natured John Leech. It was Douglas Jerrold who once remarked that Albert Smith's initials were "only two-thirds of the truth." Another writer described an early call at Percy Street where he found Smith—like a typical Bob Sawyer "with his heels upon the table playing the cornet as a grand finalé to his breakfast." After the break with *Punch*, Smith discarded writing for a new and, as it turned out, most profitable career. This was as lecturer and popular entertainer, and for many years he addressed crowded houses at the Egyptian Hall on a variety of subjects. This venture was not only profitable but was said to have brought about a great change in his character, in fact, one who claimed to know Smith well, said that "though vulgar and bumptious in manner, he became polished by consorting with swells, after becoming a public entertainer." As his agent and business manager, he employed his brother Arthur who also was a doctor, but gave up practice to devote his whole time and energy to looking after his brother's affairs.

At the early age of 44 he died, "the best abused humorist of his day."

I stated at the beginning of this article that the fourth of the Bart.s friends all of whom became closely associated with the founding of *Punch* was Gilbert à Beckett, who shared "digs" with John Leech and Percival Leigh. Whether à Beckett was a medical student for a while is uncertain, but his brother Arthur who was at Bart.'s, qualified and served with distinction in the Army Medical Corps.

It is a pity so little is known about the daily round of a London medical student in the early part of the last century. Indeed, at Bart.'s there is actually no list or record of the names of the students who learned their medicine at our hospital under such great teachers as Stanley and Paget.

SO TO SPEAK . . .

To conclude an experiment with a spirometer:

". . . expire gently into a Gladstone Bag. . . ."

A physiology examination candidate.

Even his best friends . . .

". . . he bought twelve cases of mouthwash and then found his friends didn't like him anyway."

Alexander Woolcott.

Was it Rabies?

BARKING SCHOOLBOY SHOT.

Headlines from a local paper.

On being awarded an Honorary Doctorate of London University.

". . . it is a great honour, and anyway one's wife likes these things."

Professor Van Slyke.

This England.

"Under the National Health Scheme people can have drugs supplied to them, that is all right for those people who have no intention of taking their life, but for people who are fed up, such a state of affairs gives them the opportunity to end their lives. Such people are abusing the advantages given to them."

Walthamstow Post

Three Aphorisms:

On the use of purgatives—

"Sometimes then and now, but my God, always never."

"There is a place in the world for everyone, even the worst of us can serve a horrible examples."

"A doctor should know a little about everything, including medicine."

Voltaire

THE SURGICAL TREATMENT OF CONGENITAL HEART DISEASE

By GEORGE KAZANTZIS

Much progress has recently been made in a new field of surgical endeavour, that of the heart and great vessels. Many forms of congenital heart disease can now be treated successfully by operation, and the accurate diagnosis of this condition, until recently an academic exercise, has assumed great practical importance. The progress which has been made is reflected in the increasing amount of cardiac surgery now being performed on the Thoracic Unit at Hill End.

Congenital heart disease constitutes 1.5 to 2.5% of all cases of organic heart disease, and it may be argued that this branch of surgery is small and highly specialised. Every cardiac operation performed, however, gives us information on the reaction of the heart to surgical interference, and furthers the development of a technique in this new field.

Thus the way is being opened for the surgical relief of the more important field of acquired heart lesions. Mitral valvulotomy, the intra-cardiac operation for the relief of mitral stenosis, has been performed at Bart.'s on about a dozen occasions, and will be performed with increasing frequency in the near future. It is not too much to hope that the day will soon come when the many thousands who suffer from valvular heart disease will be afforded radical treatment for their incapacity.

The history of cardiac surgery is short, and can be traced back to 1897 when Rehn described the successful suture of a cardiac wound.

Isolated attempts were made to divide stenosed valves by Doyen and Tuffier in 1913, by Souttar in 1926 and by Cutler in 1929, but modern cardiac surgery really commences with the first successful ligation of a patent ductus arteriosus by Gross and Hubbard in 1939[1].

In November, 1944, Blalock[2] performed his first "blue baby" operation in America, and in the same year a coarctation of the aorta was resected by Crafoord and Nylin in Stockholm[3]. In 1948 Brock performed his first direct cardiac operation on the pulmonary valve[4] at Guy's Hospital, and a year later, he successfully split a stenosed post rheumatic mitral valve[5].

These epoch making advances were made possible by a number of developments in the preceding years. The perfection of anæsthesia with the use of curare and controlled respiration, making exacting work like arterial suture on a mobile mediastinum technically possible; the technique of thoracotomy and closed drainage; intravenous infusion of fluids and blood; chemotherapy and pre- and post-operative care of the patient, are some of the vital accessories which have made cardiac surgery possible. The physiological basis of all this work must not be forgotten.

Patent Ductus Arteriosus

This condition is often symptomless in young children, the cardiac murmur often being first heard on routine examination. Some children have a retarded physical development, and are more than normally liable to intercurrent infections.

The open ductus is, in effect, a fistula which at first shunts blood from the aorta into the pulmonary circulation. Left ventricular enlargement occurs in time, with dilatation of the pulmonary arterial tree. These patients are particularly susceptible to sub-acute bacterial endocarditis, which claimed a high toll before the introduction of penicillin. Very few lived beyond the age of forty, those not succumbing to infection, dying of heart failure.

The diagnosis is made on the machinery murmur; and on radiography which shows a prominent pulsatile pulmonary arc with increased hilar shadows. In more difficult cases the ductus may be visualised on angio cardiography or retrograde aortography. Cardiac catheterisation may show an increased pulmonary arterial pressure, and blood samples obtained from the pulmonary artery a raised oxygen saturation due to admixture of arterial with venous blood. A lowered diastolic blood pressure is present in many cases.

A ductus complicated by bacterial endocarditis was first successfully ligated by Mr. O. S. Tubbs in 1941[6], the blood culture becoming sterile on the second post-operative day, thus providing the first cure of, till then, a fatal disease.

Operation, usually consisting of simple ligation of the ductus, is advised in children between the ages of five and fifteen unless there is a specific contra-indication. Here is a typical example.

Muriel—Age 5½

Asymptomatic, patent ductus discovered on routine examination at age of 2½.

The patient was a healthy child with normal development. A systolic thrill was palpable in the 2nd and 3rd left intercostal spaces, where a continuous murmur was audible maximally. The blood pressure registered 110/50.

30.3.51. Operation: Theatre "C." Ligation of patent ductus arteriosus by Mr. I. M. Hill.

Anæsthesia by Dr. R. A. Bowen. Premedication with seconal and atropine, then pentothal, gas, oxygen, ether and curare.

A left posterolateral thoracotomy was performed through the fourth rib bed. The upper lobe of the lung was held back with a retractor and the mediastinal pleura incised between the vagus and phrenic nerves. The recurrent laryngeal nerve was defined curving below and behind the arch of the aorta, and the ductus, which was short and wide, was identified medial to it. The most exacting part of the operation is the careful dissection of the ductus, which has to be cleared completely. When the ductus was quite free, it was ligated first at the aortic, then at the pulmonary end with floss silk, and then transfixed and tied again between these ligatures with thread.

After ligation the blood pressure registered 110/80 and the continuous thrill could no longer be felt. The lung was re-expanded, a basal drain inserted and the chest closed in layers with nylon. Post-operative recovery was uneventful, the drainage tube being removed on the second, and the child being discharged home on the tenth post-operative day.

Tetralogy of Fallot

Failure of the normal development of the heart producing some form of pulmonary stenosis, a ventricular septal defect, dextroposition with over-riding of the aorta so that it communicates with both ventricles, and a hypertrophied right ventricle, is the commonest form of congenital cyanotic heart disease.

The reduced blood flow through the lungs and the right to left shunt produces a decrease in the oxygenation of the arterial blood, which is responsible for the patient's symptoms. The object of surgery is to provide a means whereby the oxygen saturation of the blood can be increased.

Blalock accomplished this by anastomosing a systemic to a pulmonary vessel, thus increasing the flow of blood to the lungs by by-passing the obstruction. The operation has had brilliant results. However, it neither relieves the obstruction nor alters the flow of venous blood into the arterial circulation through the patent septum. It can be seen that, in effect, an artificial patent ductus arteriosus is created, and the patient is left with an arterio-venous fistula, a condition in itself bearing a doubtful ultimate prognosis.

Brock has dealt with the problem by a direct attack on the stenosis by performing a pulmonary valvulotomy—i.e., dividing or dilating the stenosed valve, approaching it through the wall of the right ventricle. Thus, the obstruction relieved, not only is the pulmonary blood flow increased, but as a result of the fall in pressure in the right ventricle, the right to left shunt is diminished.

Pulmonary valvulotomy has been performed in cases of pulmonary stenosis without ventricular septal defect where the Blalock type of operation is unsuitable, also in those cases where the Blalock operation is not anatomically possible due to the arrangement of the great vessels.

Barrett has attempted to increase the pulmonary blood flow by creating adhesions between the lung and the chest wall, and has met with some success. This operation can be used where the above two are impracticable, as in cases of atresia or absence of the pulmonary artery.

Children with Fallot's tetralogy are usually small and under weight, slow in development and often mentally retarded. Exertion produces an increase in their cyanosis which is usually present to a certain extent from birth. Dyspnoea may limit the child to walking only a few steps without resting, often in the characteristic squatting position. Severe dyspnœa with intense cyanosis sometimes occurs in spontaneous attacks, which may end fatally.

Gross clubbing is seen in the fingers and toes, producing the characteristic "drumstick" appearance. The extremities are usually cold.

The low arterial oxygen saturation produces a compensatory polycythæmia, so that red cell counts of eleven million with a hæmoglobin of 180% are occasionally found.

A systolic thrill with a harsh systolic murmur maximal to the left of the sternum, is usually heard.

Chest X-ray shows a characteristically sabot-shaped heart with a blunt elevated

apex, a concave pulmonary bay and clear lung fields without visibly pulsatile vessels, due to poor vascularity. Angiocardiography showing the anatomy of the great vessels is invaluable in planning surgery, which requires the presence of both pulmonary arteries and a systemic vessel in suitable proximity for anastomosis. Cardiac catheterisation demonstrates the increased right ventricular pressure and the decreased pressure in the pulmonary trunk.

These children all deteriorate gradually, so that only one blue baby in two will attain the age of seven and less than one in ten the age of twenty-one. The operative risk has been estimated at about 12 to 16%. Great improvement takes place after operation so that children who had been able to walk only a few steps can play and walk normally; the colour becomes nearly normal, the polycythæmia disappears and the clubbing subsides. The heart enlarges a little, due to the creation of an arterio venous fistula. Not knowing the ultimate prognosis we can only say at present that many of Blalock's early cases are well six years after operation.

Margaret, Age 3.

Had spasms of difficulty in breathing, when she would become blue and often lose consciousness. Prior to admission she had been having between three and seven such attacks daily. She also became dyspnœic walking ten yards on the level. She crawled at ten weeks, walked at fourteen months, and never squatted. At the age of three months she had bronchopneumonia, when the cardiac lesion was discovered.

Margaret was an intelligent lovable child, slightly built, with cold, blue extremities and gross clubbing of her fingers and toes. She became markedly cyanosed on crying.

A systolic thrill was palpable, and a loud, high pitched systolic murmur could be heard maximally over the second and third left interspaces. Her radial and femoral pulses were equal on both sides and her blood pressure was 120/80. Chest X-ray showed a small heart and oligæmic lung fields. The E.C.G. showed right ventricular hypertrophy. Simultaneous filling of the pulmonary artery and the aorta was shown on angiocardiography, demonstrating a large ventricular septal defect, a normal left subclavian artery and adequate pulmonary arteries.

30.1.51. Theatre "C." Left subclavian pulmonary anastomosis by Mr. I. M. Hill.

Anæsthesia by Dr. R. A. Bowen. Rectal pentothal was given in the ward, followed by gas, oxygen and ether in the theatre. 150cc. dextran was given intravenously during the operation.

A left posterolateral thoracotomy was performed through the bed of the fourth rib, and the upper lobe of the lung collapsed and held back with a retractor. The morphology of the pulmonary artery was noted very carefully. The thrill was maximal at valve level, the valve cone was not felt, the artery was of low tension and without poststenotic dilatation.

The pleura was incised over the pulmonary artery and the latter mobilised carefully by blunt dissection. The subclavian artery was similarly mobilised and its terminal branches were ligated. A bulldog clip was applied to the artery proximally, which was then divided through the origin of the vertebral artery, thus giving it a wide mouth. The pulmonary artery was occluded proximally with a Blalock clamp and distally with a bulldog clip and silk sling. The subclavian artery was turned down and an end to side anastomosis performed with the pulmonary artery so that a "T" junction was produced. The arterial suture was performed with 5/0 silk thread on a fine atraumatic needle. A continuous everting suture was used, the stitches being placed 1mm. apart, 1mm. from the edge of the vessels. Neither arterial wall nor thread was touched with forceps. The anastomosis is the crucial part of the operation, requiring about half an hour to perform. No bleeding occurred when the occluding devices were withdrawn. A good continuous thrill was felt over the site of the anastomosis.

The lung was inflated, a basal water seal drain inserted, and the chest closed in layers with nylon.

Post-operative recovery was uneventful, the patient being nursed for the first two days in an oxygen tent in the routine manner. The patient was discharged 18 days after operation. When seen again four months later she was well, could play and run without dyspnœa, and had had no further unconscious attacks.

Coarctation of the Aorta

In the adult form of coarctation, which is the form amenable to surgery, there is an annular constriction of the aorta at the level of the ligamentum arteriosum, which latter is sometimes patent. The symptoms, signs and pathology result from the hypertension present proximally to the construction, i.e.,

in the head and neck, and arms. Many young patients are symptom free; some, with a mild degree of coarctation, never develop symptoms. However, the average age of death is about 35 years, so that the condition must be regarded a serious danger to life. Long-term strain on the left side of the heart eventually causes cardiac failure, or the patient may die before this from cerebral hæmorrhage, rupture of the aorta or subacute bacterial endocarditis.

The early symptoms are those of hypertension. Examination shows prominent arterial pulsation in the neck and upper limbs in marked contrast to the feeble or absent pulsation of the femoral artery or dorsalis pedis. The blood pressure in the arms is frequently over 200 mms. of mercury. Pulsating vessels may be felt over the chest wall. The heart is often enlarged, and a systolic murmur may be heard over the aortic area.

The X-ray may show notching of the lower borders of some of the ribs due to the pulsating intercostal arteries, an enlarged heart, and an abnormal aortic arch. The constriction is usually seen on angiocardiography, but retrograde aortography may be necessary. It is preferable to visualise the coarctation before deciding on operation, as the constriction may be too long for resection without the use of an aortic graft. The operation consists of resection of the constriction with end-to-end anastomosis of the cut ends of the aorta. Part of the aorta must be mobilised in order to bring the cut ends together. This is most easily accomplished in a young child, so that this is the optimal age for operation. An aortic graft has been successfully used by Gross to bridge the gap in a few cases.

H.C. Aged 14.

The patient was completely asymptomatic. A cardiac murmur was noticed at the age of five and a diagnosis of congenital heart disease made. The patient was subsequently forbidden to play games at school. Examination showed an intelligent, well developed youth. Vigorous pulsation could be seen in the neck and could be felt medial to the scapular margins on the back. The cardiac impulse was thrusting, and the apex beat placed half an inch outside the midclavicular line. A loud systolic bruit could be heard over the præcordium. The blood pressure in the right arm was 160/115. The femoral pulses were not palpable.

5.3.51. Operation: Theatre "C." Resection of coarctation and aortic anastomosis by Mr. I. M. Hill.

Anæsthesia by Dr. R. A. Bowen. Pentothal, gas, oxygen and curare. 4½ pints of blood were given during the operation.

A left posterolateral thoracotomy was performed through the bed of the fourth rib. Large collateral vessels had to be tied in the chest wall. The coarctation, which was easily visible just below the origin of the subclavian artery, was dissected out, and tapes were passed round the proximal and distal ends of the aorta. As the intercostal vessels were being dissected off the chest wall to allow for further mobilisation of the aorta, one of them parted company at its origin. Torrential hæmorrhage occurred before the bleeding points could be controlled, so that although a pressure transfusion through two drips was being carried out, the heart stopped beating momentarily, to be restarted by massage. This incident illustrates well the technical difficulties of such an operation. After ligation and division of the proximal intercostal vessels and the ductus arteriosus the proximal and distal clamps on the aorta were adjusted and the coarctation was resected.

End to end anastomosis was easily carried out with a 3/0 everting mattress suture, after which the distal aortic clamp was released, followed by the very slow release of the proximal clamp. No significant leakage from the anastomosis occurred; the chest was closed in layers in the usual way, after the insertion of a basal intercostal drain.

For the first two post-operative days, due most probably to the cerebral anoxia caused by the sudden severe blood loss, the patient was semicomatose. Thereafter he improved rapidly, so that on his discharge one month later he was perfectly well. The blood pressure fell gradually, and on discharge registered 128/96 mms Hg. in the right arm. The pulses were normally palpable in the lower limbs.

I wish to thank Mr. I. M. Hill for permission to publish these cases, and for very kindly looking through the manuscript and making many helpful suggestions.

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CORRESPONDENCE

CHARTERHOUSE SQUARE ARCHITECTURE

To the Editor,

St. Bartholomew's Hospital Journal.

Dear Sir,

Congratulations to your critics of the New College Hall, Charterhouse Square, but just what *do* they mean by the curious phrase "The most encouraging thing about the new hostel is the ubiquitous acceptance of the forthcoming 'Scandinavian' style of our buildings, furniture, and textile patterns . . ." Surely, the most encouraging thing is not the "ubiquitous acceptance" of anything, but that the College have triumphed over countless difficulties and are at last able to give us a comfortable and convenient place in which to live. Now when this involved sentence is further examined, one cannot do otherwise than conclude that these critics consider the New Building to be in the Scandinavian style, and that this is the coming style in English architecture. This is very far from the truth.

The modern style in architecture has come about as the result of a struggle to find beauty and utility within the opportunities that the architect is given and restrictions imposed on him by needs and materials. Modern architecture verges toward functionalism owing to the new opportunities given by steel, glass and concrete in designing industrial buildings, blocks of flats, government departments, etc. The first building to exploit these possibilities was our own Crystal Palace, designed by Paxton just one hundred years ago. But in Britain we did not see fit to follow his example. It was Behrens and later Walter Gropius, in Germany, who were really the first to take the full advantage of new engineering feats, and Le Corbusier, who tried to put into architectural practice the ideals of his social Utopia. Under the influence of Gropius' *Bauhaus*, which was little more than a newly constituted concern with the same ideas in mind as our own William Morris' circle, the new movement spread to America, France, Switzerland and other European countries and finally reached Scandinavia. Here it was incorporated with the former true Scandinavian style of folk origin, and took root so firmly and so completely that only in these countries does modern architecture exist without self-consciousness rather than appearing the choice of a sophisticated minority.

In our New Building there are none of the characteristics that one looks for in the Scandinavian style. The materials that have been used are local and typical of London, not of Scandinavia. No use has been made of the processed concrete surfaces employed in Denmark, but impossible in our climate. The pitch of the roof is not characteristic. Wood, which is so freely and effectively used for construction and decoration in Norway is here almost limited to a single stair rail. Though these critics might choose a vase of the T'ang dynasty (a particularly dull phase of Chinese art) the architect has made no use of sculpture, as in Finland where it gives a goal and perspective to the corridors; or to break up and give relief to the flat walls of the stairway or the exterior, as seen in Sweden.

So far, then, there is little Scandinavian influence to be seen, so what of the furnishings and textiles? The three successful exhibitions: Malmo, Copenhagen and the culminating one at Stockholm have dubbed all subsequent efforts to return to the simple style of a folk art as being under a Scandinavian influence. Have these critics so soon forgotten the original work of John Ruskin and William Morris? Modesty has its place but our country cannot afford to allow other nations to take the credit due to herself. It is time that we brought out our own lights from under our bushels. The enormous success of the architecture of our Festival has shown the world that we can make the best use of available materials and we have the liveliest of modern architecture. These critics say that the New Building owes no inspiration to the South Bank, yet they themselves admit that they were constantly reminded of the Homes and Gardens Pavilion!

No sir, Scandinavian architectur is not "ubiquitously" accepted neither is it "forthcoming". The New Building is an example,—I do not say one of the best—of the new school of British Architecture, of which we have every right to be proud.

I am, sir,

Yours, etc.

JOHN BARLEYCORN

Abernethian Room.

STUDENTS HALF-PRICE

To the Editor,
St. Bartholomew's Hospital Journal.

Dear Sir,

I wish to lodge a strong protest against the attitude which the organisers of many recent art exhibitions adopt towards medical students. "Students half-price" is a notice frequently displayed, but on production of my hospital card I am told that this only applies to Art students. I encountered this reaction at the Picasso exhibition, and later at the Toulouse Lautrec exhibition, both at the New Burlington Galleries, and recently at the Munch exhibition at the Tate. Such notices should be changed to bear out the facts or preferably this privilege should be extended to all students.

Yours, etc.,
LORE FELDBERG.

Abernethian Room.

STUDENT RESPONSIBILITIES

To the Editor,
St. Bartholomew's Hospital Journal

Dear Sir,

Although I am bound to agree with Professor Sir James Paterson Ross that there are innumerable opportunities open to the student, I do not think that the student is encouraged to do as much as he was in Mr. Hadfield's days.

It seems, from talking to my contemporaries, that dressers on the Surgical Unit are encouraged to do more, especially in the theatre and on out-patients, than on any other firm. I, personally, found, as a dresser, that it was difficult to get the nurses to leave the dressings of my own patients for me, even after I had told Sister that I would do them.

My greatest complaint, however, is about the Casualty Department in which I was only able to work for three afternoons and two evenings during my three months' dressing. In that time I managed to put in stitches twice, whilst some students had no opportunity to do it at all.

As far as I can see, the only other time the student has in that department is four mornings during his Surgical Out-patient appointment, which occurs two years before he qualifies.

I do not wish to criticise my own hospital, but I do find that students in some other London hospitals live in and are on duty in the Casualty box for at least a week or a fortnight. This gives them a longer time in which to become used to the practical details essential for general practice, than we have in our hospital.

Now that the second surgical firm has been abolished (a measure of which I am in favour, as much time is wasted doing surgery when one can often learn more from patients on a medical firm) it does seem essential that the student should have more practical work some time during his training.

Though I feel unqualified to make such statements with only a few months' experience in the hospital and before doing my Surgical Out-patients' appointments, I do think it necessary to express my views while the subject is "being considered."

Yours faithfully,
ANTHEA BLOFELD.

Abernethian Room.

A BAKER STREET CORRESPONDENCE

The Editor,
St. Bartholomew's Hospital Journal.

Dear Sir,

I read the article on Mr. S. Holmes, Dr. J. Watson and Bart.'s with great interest and I am sure it filled a gap in the higher criticism. Although the vital part this hospital played in the lives of these two men was ignored by the Councillors of Marylebone it is remembered by others. At a recent meeting of the Sherlock Holmes Society of London there was present an American who suggested a plaque should be erected either in the Criterion bar or in the chemistry laboratory at Bart.'s to commemorate the fateful introduction of Dr. Watson to Mr. Holmes.

I do not know if any final decision about the site of this plaque has yet been made. Undeniably this hospital has the more substantial claim as the place of the actual meeting. If we still feel pride in these former Bart.'s men we should make every effort to support our claim.

Yours faithfully,
GILLIAN FRANCE.

Abernethian Room.

I am told by the organiser of the Abbey House Exhibition and a leading Sherlockian that a plaque presented by the *Baritsu Chapter of Tokyo* is already marking that fateful meeting in the Criterion Bar.—EDITOR.

WATSON MATTHEWS DUNCAN'S DRESSER?

To the Editor,
St. Bartholomew's Hospital Journal.
Dear Sir,

I was interested in reading the article in the last number on Sherlock Holmes and Dr. Watson at Bart.'s, with some of the suggestions about his early medical career.

I cannot accept the view that Dr. Watson was H.P. to Dr. Samuel Gee. Stamford was a dresser under him, presumably while he was a house officer, and surely this implies that he was a house surgeon, or perhaps on the obstetric side? The fact that he took the M.D. (London) rather than the M.S. might fit in better with the latter, and in the lecture which I gave to your Abernethian Society —now some fifteen years ago—I suggested that he had probably been resident to your great obstetrician Matthews Duncan.

It seems to me important to settle the site of the famous meeting between Watson and Holmes in the old chemical laboratory, and I was especially interested in learning about the private pupils who were taken by Augustus Mattieson, at that time.

Yours sincerely,
MAURICE CAMPBELL.

Guy's Hospital,
London, S.E.1.

WATSON'S WAR-WOUNDS

The Editor,
St. Bartholomew's Medical Hospital Magazine,
Dear Sir,

I was glad to see the pictures I lent you came in useful for the interesting article about Mr. Holmes and the Dr. in your magazine last month. I can't say I understood it all properly but it seemed to me that you were trying to work out whether the Dr. had been wounded in the leg or in the neck. This seems queer to me for the fact is I always understood from my Aunt that the Dr. had been wounded in both places. I often heard Aunt speak about the nasty scar at the root of his neck which she often saw in the mornings when she took up his tea in the nightshirts what gentlemen wore in those days.

About the one in the leg I remember my Aunt being cross with me when a little girl because I asked what made the gentleman walk funny and Aunt told me to hush because the Dr. was a very brave gentleman that had been wounded fighting for the Queen. Dear, oh dear, what a long time ago it seems now.

Well I hope this will give you a clue, as the saying goes.

Yours respectfully,
ELSIE HUDSON (Miss).

1B, Victoria Mansions,
Willoughby Crescent,
Euston.

To the Editor,
St. Bartholomew's Hospital Journal.
Dear Sir,

The ingenious but rather fantastic article on the career of Dr. Watson, in spite of its elaborate documentation, makes many unreasonable assumptions. There is not the slightest evidence that Watson ever underwent any operation and the assumption that a tenotomy of the tendo Achillis was performed is unjustified.

On the medical side I fear that the writer of the article can never have seen a case of typhoid fever; if he had he would know that patients suffering from that disease would never be put into the Fowler position.

I beg to remain,

Yours rather perturbedly,
ZETA.

Another Medical School.

Watson, you were indeed the perfect friend,
Unquestioning you did as you were told,
And stood your ground to see events unfold,
Not knowing what might be the bitter end;
By you it was that all those tales were penned,
To *Holmes* you were well worth your weight in gold,
Though cast in absolutely different mould
Your genius with his made perfect blend.
Yet both were children of a greater man
On whom for ever rests our benediction,
For from his fine imaginings began
That famous trinity of fact and fiction:
The world of crime together they could foil—
John Watson, Sherlock Holmes and *Conan Doyle*.
ZETA.

Watson himself, it will be remembered, was a great admirer of Petrach's Sonnets.—Editor.

Does anyone know the whole story?

SNUFFBOX—REWARD for recovery of silver 18th century inscribed "Snuff box of Jenkyn Lloyd of Clockuan, murdered by his doctor."

—*From THE TIMES personal column.*

"ARSENIC AND OLD LACE"

I contend that an amateur performance is frequently more entertaining than a professional one. Personal performances are remarkable as a rule rather than an exception. When they are only moderate one can admire the actor's valour in coming on at all, but when they are really good amazement gives almost as much pleasure as the excellence of the acting.

In this year's production there was an almost constantly high standard of personal performance, and only sufficient of the valour for one to appreciate its presence. Especially to be applauded are Miss Carice Ellison and Miss Wendy Cook, who took two long and difficult parts, assuming the mantle of years with commendable assurance. Richard Nainby-Luxmore appeared to thoroughly enjoy, as did all of us, the part of Teddy Brewster, which he played with great confidence, his occular powers emulating those of Eddie Cantor.

Mr. Richard Nainby-Luxmore [*Masheter.*
Miss Wendy Cook *Miss Carice Ellison*

Sheila Dennis as Elaine Harper and Gordon Reed as Mortimer Brewster were, as is most proper on these occasions, charming. Not being character parts, they were both difficult, and I think well played, though I think the producer should have damped down Mortimer Brewster's earlier enthusiasms to leave him some emotional reserve for the trials to come later. I think a more definite stand could have been taken concerning accents, which ended up as a mixture of American and English. It was good to see that we provided our own producer from Bart.'s this year.

Graham Thompson was most convincingly psychopathic as Johnathan Brewster. Bert is to be congratulated on his formidable appearance and remarkable resemblance to Mr. Karloff, the rest of the make-up continued in his tradition of excellence. Michael Perkins as his partner in crime battled valiantly with the double load of the assumption of villainy and a mid-European accent, only marred by being occasionally difficult to decipher.

Of the smaller parts all were enjoyable. Robert Roxburgh seemed at home in a dog collar. The play as a whole was a delightful affair and a sound choice for the occasion, though I for one would rejoice to see the Society undertake one of the more robust restoration plays, though I admit the difficulties of production are considerable. This will probably be the last play produced by the Society with which John Pittman is associated. After so many years' work for them I am sure the Society will be sorry to see him leave the rank and file to join the hierarchy of the profession.

I think we must congratulate all concerned for providing a most enjoyable evening's entertainment. J. A. L.

[*Masheter.*
Miss Carice Ellison *Mr. Robert Roxburgh*

THE IMPORTANCE OF BEING UNQUALIFIED

By "FFORTUNE"

GEORGE BERNARD SHAW took the utmost advantage of being unqualified. His half-knowledge of things medical allowed him to advocate all the unregisterable '-opathies', and even to sample them: a homeopath cured the Shavian hydrocele, with what even Shaw suspected of being sugar in minute doses!

In 1922 he addressed the Abernethian Society[1] on "The Advantages of being Unregistered." While, unfortunately, no complete record exists, there is no doubt that he was well, but by no means seriously, received. It seems to have been a happy affair. A similar talk at St. Mary's was spoiled for Mrs. Shaw by the Chiefs, who puffed away at their cigars throughout his talk. At Bart.'s we must surely have realised that this was 'bad form,' even if we forgot Shaw's views on smoking. Although this was his best known connection with Bart.'s, it was not the only one; and is but a drop in the sea when compared with his other medical associations.

G. B. S. in 1881

In the 1880s Shaw was a great friend of Dr. Kingston Barton, a 'Perpetual Student' of this Medical College. (An honour—we can almost hear Shaw saying it—comparable in its stupidity with the Order of the Bath.) The originals of two poems[2] addressed to Dr. Barton are in the College Library; they make us wish that Shaw had tried his hand at this kind of thing more often:

'May his profits quicken
His skill find constant use,
May the neighbours sicken
Like the very deuce.'

Later in life he wrote to the Librarian here: "I have no objection to the publication of this doggerel in the Bart.'s H.J., though if I were editor I should burn it."

In his medical writings Shaw shows his usual mixture of deep perception and thinly veiled folly, of seriousness and high humour. Thus we find the strangely perceptive statements[3]: "... he who cuts out your insides receives hundreds of guineas, except when he does it on a poor person for practice", and "Nothing is more dangerous than a poor doctor," in the same volume as this advice to the general public: "Take the utmost care to get well born and well brought up." Oh! that he were alive today to champion the all too poor General Practitioner, so meagrely provided for by the Health Scheme. As long ago as 1917 he foresaw that General Practice was destined to disintegrate into a sorting-house for the specialists; and he pleaded "Wanted: A State Medical Service," but he did stipulate that it should be a well-paid one. In the Shavian Health Scheme a central authority would fix the figures for the incidence of disease and for mortality; should the figures be exceeded, the Doctors would be penalised. A whimsical idea? ... well, it just depends on whether *you believe* in payment by results.

Shaw's seemingly fantastic medical opinions are far too prolific for me to more than hint at them here; his letters to the *B.M.J.*, to *The Times*, and to many other papers have all been published[4] and make not only amusing but highly provocative reading. The reader should not do more than bear his views in mind, he will never get a House job if he takes them to heart! One day—who knows?—Shaw may be

regarded as the great prophet of medicine: some of us have even heard a lecturer at Bart.'s admit that although the Doctors Dilemma angered him much at the time of its publication, its truths had been increasingly brought home to him since!

In 1929 the Dramatic Club of our hospital planned to give performances of Arms and the Man, but they failed to get permission. When Shaw heard of this he wrote to the Clerk of the Governors:

> "I do not know whether the Governors intend to offer their guests any refreshments, and, if so, whether they are asking the caterers to supply them gratuitously; but if so, they are treating me worse than the caterers because the 2,000 persons, being fed, will be as hungry as ever next day, whereas their appetite for the play may be so satisfied that the next manager who offers them a performance of it on the usual terms will offer it in vain . . . next year, please turn your attention to Shakespeare. He is no longer obliged to live by his work, as the live playwrights are."

Shaw honestly thought that he was getting a raw deal. In his medical writings he showed again and again that he felt the patient to be getting a raw deal. In the case of the play he waived his fees. The interests of the patient he would *not* waive. We should be failing in our duty as a profession if we were to ignore the views of a great and inarticulate section of the laity which found expression in Shaw's writings.

I can only conclude, as Shaw concluded a letter to his publishers in 1887, by wishing the reader the "compliments of the detestable season." Yes, Shaw, not Scrooge.

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[1]Abernethian Society Minutes Book. June 8th, 1922.
[2]St. Bartholomew's Hospital Journal, 1947, p.26.
[3]Preface to the Doctors Dilemma.
[4]Doctors Delusions.

Permission to include the quotations has been granted by the Public Trustee and the Society of Authors.

RENAL TUMOURS

By MAURICE LUNN.

THE object of this short paper is to place on record an analysis and follow up of the cases of renal tumour which were admitted to this Hospital between the years 1932 and 1950. Those of 1935-50 were included in the large series of 2,314 cases presented to the Annual Meeting of the British Association of Urological Surgeons by Riches, Griffiths and Thackray (1951).

Only histologically proved cases whose notes have been traced are included This means that patients classified as "Explored" or "No operation" are few in number, as only those in the former group who had a biopsy performed and only those in the latter group who died in hospital and who were examined post-mortem qualify for inclusion.

The total number of cases available is 52. These are classified histologically in Table I. The term adenocarcinoma is used to describe the parenchymal carcinoma in preference to the older term hypernephroma.

Of the 35 adenocarcinomas one is considered to have had a bilateral lesion in that after removal of a large tumour on one side he was found post-mortem to have an equally large tumour on the other side. It is of interest to note that neither of the two pelvic squamous carcinomas was associated with a stone, although a calculus was present with one of the transitional celled carcinomas. The origin of the fibrosarcomas is not known for certain, but as the tumours were involving the kidney they presumably arose from the capsule.

TABLE I

	Type of Growth	*No. of Cases*	%
1.	Adenocarcinoma	35	68%
2.	Transitional celled Carcinoma of Pelvis	6	
3.	Squamous celled Carcinoma of Pelvis	2	
4.	Papilloma of Pelvis	2	
5.	Adenoma	1	
6.	Wilm's Tumour	2	
7.	Fibrosarcoma	3	
8.	Leiomyosarcoma	1	
			32%
	Total	52	

Age. The two patients with a Wilm's tumour were aged 1 and 1½ years. The range of the remaining cases was from 23 to 69 years. The patient aged 23 was suffering from an adenoma. The youngest patient with an adenocarcinoma was aged 28. The incidence of adenocarcinoma rose with age to a maximum in the seventh decade whereas the incidence of the remaining lesions was practically constant in the fifth, sixth and seventh decades.

Sex. There were 36 males and 16 females.

Side Affected. Right 23, left 30. (One bilateral.)

Symptoms. Haematuria, pain and tumour were the main presenting symptoms. A number of cases had only general symptoms and these were usually inoperable patients with widespread metastases. Pain in the groin due to a recent varicocele led to the doctor discovering a mass on one occasion. Haematuria was present in 27 of the 35 adenocarcinomas, in 9 of the 10 pelvic growths, in one Wilm's tumour and in one fibrosarcoma.

I think it important to stress the fact that in a number of patients the making of a correct diagnosis was delayed because of a failure to investigate thoroughly a patient complaining of haematuria, such as attributing the bleeding to the prostate without a pyelogram being performed.

"Pelvic Growths."

Operation Deaths. There were two deaths on the table: one was found post-mortem to have malignant emboli in the pulmonary artery, the other was operated upon with a Haemoglobin of 45% and was not transfused during operation. One patient who had an inoperable lesion died the following day. The patient with a bilateral adenocarcinoma died after 17 days, having had a suprapubic cystostomy performed for repeated clot retention. The fifth patient died after three weeks.

Two patients should not have had a nephrectomy. The first was the case with the bilateral lesion already referred to. The second was a woman of 53 who had pain in the left side and haematuria. Cystoscopy and a pyelogram were normal. She was found to have an enlarged supraclavicular gland which was removed, the histological report stating that it was lymphadenoma. She received Deep X-ray therapy but she was re-admitted six months later with further hæmaturia. There was a mass in the left side which was thought to be spleen, but on further cystoscopy no dye was excreted from the left ureteric orifice. Left nephrectomy was performed, the kidney containing an undifferentiated carcinoma of renal tubular origin. When this section was compared with that of the gland it was realised that the latter was a metastasis of the former. She survived operation by two months.

TABLE II

	Nephrectomy	*Exploration*	*No operation*	*Total*
Adenocarcinoma ...	24	4	7	35
	(4)	(1)		
Pelvic Growths ...	10*	—	—	10
	(–)	(–)		
Other Lesions ...	6	1	—	7
	(–)	(–)		
Total	40	5	7	52
	(4)	(1)		

The number of post-operative deaths is shown in brackets.
Operative mortality 11%.
* The two cases of papilloma of the pelvis both underwent ureterectomy, one 1 and the other 3 years after nephrectomy.

Treatment and Operative Mortality. Of the 52 cases 40 underwent nephrectomy, there being four post-operative deaths, all cases of adenocarcinoma. Five patients were explored, found inoperable and a biopsy performed. Seven proved cases died with operation.

The operations performed for the various lesions are shown in Table II. Groups 2, 3 and 4 (from Table I) are combined as

Results of Nephrectomy. Deep X-ray therapy was given post-operatively to a few patients but the number is too small to allow of satisfactory analysis. In the larger series referred to above post-operative irradiation significantly improved the survival rates.

Of the 52 patients the follow up of 50 is complete. One patient was lost sight of after

discharge from hospital and one was followed for only one and a third years. Neither of these patients has been traced. All patients dead are assumed to have died of recurrence. In many instances only the date of death had been found by Somerset House.

The 3 and 5 year follow up figures for those who underwent nephrectomy are shown in Table III. Operation deaths are included.

8 months, 3 months and 1 day, and one with a sarcoma who was lost sight of on discharge from hospital.

The variation in the behaviour of the adenocarcinomas is also of interest. One tumour which was known to have been present for over 16 years weighed 3,380 grams on removal, whereas another patient died of widespread metastases from a tumour only 1.8 cms. in diameter.

TABLE III

	3 year follow up			5 year follow up		
	Cases	*Survived*	%	*Cases*	*Survived*	%
Adenocarcinoma ...	15*	6	(40%)	13	2	(15%)
Pelvic Growths ...	9	5		7	2	
Others	4	1		2	1	
Totals	28	12	(42%)	22	5	(22%)

* Counting ½ each for the cases lost sight of in the first three years.

A survival chart prepared by the life-table method shows that in the first year there is a steep fall to 65% and that after this the fall is more gradual down to 19% at 5 years. The median survival is approximately 2½ years.

It is difficult to compare these figures with other series, but reference can be made to the large series collected by the B.A.U.S. In this there were 1,746 adenocarcinomas. Of those who underwent nephrectomy the survival rates for 1, 3, 5 and 10 years were 80%, 44%, 30% and 17% respectively. For those who had post-operative irradiation the corresponding figures were 86%, 53%, 49% and 27%.

It is of interest to consider the fate of those who were explored but found inoperable. There were five such cases, four with an adenocarcinoma and who lived 6 years,

Summary

1. Cases of renal tumour between the years 1932-50 are analysed.

2. Of the 52 cases 40 underwent nephrectomy, the three and five year survival rates being respectively 42% and 22% for all cases, and 40% and 15% for the adenocarcinomas.

Acknowledgements. I wish to thank the members of the Medical and Surgical Staff for permission to report their cases, Mr. A. W. Badenoch for his advice on the preparation of this paper, Mr. Curwen for his help in analysing the figures, and Mrs. Perkins of the Follow-up Department for tracing the fate of many patients.

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EXAMINATION RESULTS

UNIVERSITY OF LONDON

Third (M.B., B.S.) Examination for Medical Degrees

October, 1951

Honours

Evans, E. W. (Distinguished in Obstetrics and Gynaecology)

Pass

Albright, S. W.
Barnes, J.
Chitty, W. A.
Gill, R. B.
Harman, C. O. D.
Lloyd, E. A. C.
Morgan, D. J. R.
Smith, D. P. Q.
Weston, P. A. M.
Almond, F. A.
Briggs, J. H.
Cracknell, D. D.
Gobert-Jones, J. A.
Jarvis, H. C. M.
McKinna, C.
Phillips, G. D.
Stanley, H. W.
Weston, T. E. T.
Bapty, A. A.
Butcher, R. H. G.
Fallows, L. G.
Haigh, P. G.
Johnson, R. J. R.
May, A. G.
Picthall, G.
Waterhouse, J. P.
Wright, A. N. H.

Part I — **Supplementary Pass List**

Arthur, B. K.
Blau, J. N.
Brown, H. E.
Bruce, J. D.
Caplan, J.
Cave, J. D. H.
Chapman, L.
Chia, A. K.
Clappen, J. A.
Cochrane, R. C.
Cook, J.
Cookson, T. S.
Davies, G.
Davies, H. T.
Davies, P. E.
Dean, L. C.
Derrington, M. M.
Dodge, J. S.
Dreaper, R. E.
Elliott, C. J. R.
Fitt, W. P.
Frears, R. E.
Girling, J. A.
Gompertz R. M. H.
Goode, J. H.
Grassby, G. C.
Haggett, R.
Hall, M. C.
Hill, F. A.
Hill, J. J. McL.
Hughes, K. R.
Jenkins, D. G. W.
Lacey, S. M.
Lamplugh, A. N.
Lascelles, B. D.
Lewis, B.
Lockett, H. I.
Lodge, A. B.
Lumley, P. W.
Manuel, J.
Mercer, M. H.
Morgan, D. T. G.
Page, A. R. W.
Palmer, C. A. L.
Pickard, A. M.
Poole, G. H. G.
Price, M. G.
Randall, J.
Robson, B. E. C.
Romanes, J. L.
Ross, H. B.
Rosser, E. M.
Ryan, J. F.
Stanford, R. M.
Stevenson, K. M.
Stoke, J. C. J.
Tarnoky, G. E. M.
Thomas, B. D.
Thomas, H. A. J.
Todd, J. N.
Train, P.
Watts, M. B.
Wilson, M. S.
Winser, M. A.
Winston, F.
Woodruff, W. A. A.

Part II

Goodspeed, A. H.
Hazelton, S. F.
Husainee, M. M.
Parker, R. B.
Singer, G. E.
Waddy, G. W.
Watson, L. P. E.
Whittard, B. R.

Part III

Beale, I. R.
Blake, A. S.
Charles, H. P.
Cookson, T. S.
Dossetor, A. E.
O'Reilly, P. B.
Shattock, F. M.

SOCIETY OF APOTHECARIES

Medicine — **Final Examination** — **October, 1951**

Shah, M. C.

STAFF APPOINTMENTS

The following appointments to the Medical Staff have been made with effect from the dates given :—

Department of Anaesthesia

Consultant Anaesthetist ... ... Mr. R. I. Ballantine from 1.1.52
Resident Senior Registrar ... Miss L. Alexander from 1.12.51 (vice J. Matthias)

Gynaecological and Obstetrical Department

Resident Assistant Gynaecologist and Obstetrician ... ... Mr. M. P. Durham from 1.1.52 (vice J. J. O'Sullivan)

Mr. Hume's firm

Junior Registrar ... ... Mr. D. Rossdale from 1.1.52
Locum Junior Registrar ... ... Mr. R. B. McGrigor from 15.10.51 to 31.12.51 (vice K. Lawrance)

Junior Medical Registrars

Medical Professorial Unit ... Mr. L. E. McGee from 1.1.52 for one year only (vice R. Marshall)
Dr. Cullinan's firm ... ... Mr. R. C. King from 1.1.52 (vice F. G. Campbell)

Diabetic Clinic

Part-time Assistants ... ... Dr. H. W. Bunje
Dr. L. A. Robertson

SPORT

RUGBY CLUB

1st XV v. **ALDERSHOT SERVICES.** Lost 9-6.
At Chislehurst. October 27th.

Bart.'s were somewhat unlucky to lose a fast open game played in perfect conditions at Chislehurst. Bart.'s attacked right from the start but it soon became evident that the Services' hard-running outsides assisted by ineffective marking were to prove a real danger, and, in fact, after 10 minutes the Services' centre sold a large dummy to a bemused defence to score an unconverted try, 3-0. Shortly after we suffered a severe loss when scrum-half MacKay went off with an injured ankle. The pack carried on with seven men while Cohen deputised, very effectively, it may be said, at scrum-half. A few minutes later an excellent cross-kick by the Services' wing caught our defence on the wrong foot and sent the other wing over for a further try, 6-0. At this stage, the writing appeared to be on the wall, but Bart.'s rallied magnificently. The pack held its own in the tight and gradually attained ascendancy in the loose, hustling and harrying the Services completely out of their stride; so that at half-time the score was unchanged. It does seem a pity that we seem to need the stimulus of a man short to play really well.

In the second-half Bart.'s really went to town. With loose passing rushes and opportunist movements, they carried out a sustained siege into the enemy camp, both backs and forwards playing really well. Davies, Roche and Corbett each being brought down, literally, within inches of the line. At last a long run by Murphy sent Davies over for a well deserved try (unconverted), 6-3. The pressure was maintained and the score was levelled with an excellent penalty by Jones, 6-6. In the final quarter, Services came back with a terrific attack, but the defence held, only to have a penalty kicked against them in the last few minutes. So the game ended 9-6 to Services.

Nevertheless, if Bart.'s play this sort of Rugby more constructively, and with more cohesion, we should see better results in the future.

Team: J. L. M. Corbet; A. D. M. Thomas, R. D. Bailey, J. K. Hurray, D. D. Lammiman; M. J. A. Davies, A. Mackay, A. J. Gray, P. Knipe, F. I. Macadam, J. M. Jones, D. W. Roche, L. Cohen, M. Graham, C. W. H. Havard (Capt.).

BOAT CLUB

UNITED HOSPITALS' REGATTA, 1951

The Annual United Hospital's Rowing Club Regatta was held at Putney on Wednesday, November 7th, and resulted in Bart's upholding our claim to be the leading rowing hospital. Our 1st Eight began training in mid-September at Molesey, and, although we lost one of our best oarsmen, Bryan Palmer, to Clare College, Cambridge, we received a very able replacement from Westminster School in J. F. G. Pigott. During October we had three Eights training at Chiswick, the 1st Eight being coached by Mr. H. H. M. Ward of Thames Rowing Club, and the 2nd Eight by N. Whelan. We were stimulated to fanatical efforts by reports leaking through from Putney of a mighty crew of "Blues" and "Trial Caps" assembled by St. Thomas's, and although we progressed favourably, we went down to Putney with some doubts about our ability to overcome this formidable opposition.

Our fears, however, were ill-founded and after beating the London Hospital comfortably by four lengths, we proceeded to defeat St. Thomas's by three and a half lengths in the final. Our opponents individually were first-class oarsmen, but they were unable to combine as a fast crew in the short time available for training. We are grateful to John Currie for finding the time in his arduous duties as a house surgeon to stroke our crew for the fourth successive year.

Our Senior Four, perhaps, should have won their first race against Westminster Hospital; we were level for most of the course, but in the last 100 yards we became unsteady and allowed them to take the lead. It is doubtful if we should then have beaten Middlesex in the final, as this hospital had a fast four containing three "Blues."

The victories of our junior crews in both Junior events were particularly gratifying as they indicated a better standard of rowing throughout the club than was shown by other hospitals. The high proportion of pre-clinicals taking part is also a good omen for the future. In the Junior Eights our 2nd Eight, admirably stroked by Peter Mann, were given a hard race in the final by the London Hospital, but were better finishers and won by one length. Our 3rd Eight did not disgrace itself either and were close behind St. Thomas's II in their heat. Our Junior Four completed a successful day by beating St. Thomas's in the final of this event.

Representative crews were :—
1st Eight—J. M. Gray (bow), R. J. Knight, R. G. D. Newill, G. F. B. Birdwood, F. R. Spink, D. H. Black, J. F. G. Pigott, J. C. M. Currie, R. J. Blow (cox).

Members of the Winning Crews

2nd Eight—B. P. Harrold (bow), P. G. Burton, P. Sleight, I. H. Backhouse, P. J. G. Smart, G. D. Langham, J. D. Salmon, P. E. Mann, F. J. C. Millard (cox)

3rd Eight—J. R. Simpson (bow), C. G. Taylor, W. G. Harris, A. K. Thould, J. Randall, A. H. Luscombe, C. J. W. Hunter, W. P. Fitt, M. A. R. Manhire (cox).

Senior Four—R. G. D. Newill (bow, steers), G. F. B. Birdwood, J. F. G. Pigott, J. C. M. Currie (stroke).

Junior Four—P. J. G. Smart (bow), G. D. Langham, J. D. Salmon, P. E. Mann, F. J. C. Millard (cox).

BOOK REVIEWS

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY, by W. A. Norman Dorland. 22nd edition, 1951. Saunders Co., pp. 1,736. Price.

A good reference book, apart from any other quality, should be a pleasure to use. I consider it an advantage and a commendation that on looking up one word you come away having read up twenty others, and forgotten the one you wanted. Such success is achieved by the Oxford Companion to Literature and Music, Chamber's and Webster's but not "Dorland's." From this point of view this dictionary does not rank amongst their company, and not from an inherent lack of interest in its subject matter but because of the dull and staid treatment of promising material. A preface in one of the previous editions explains that through shortage of space the illustrations have had to be cut down, as has some of the material; this, together with the fact that this is a dictionary not an encyclopedia, is the probable explanation. But surely in a work of this kind it is the approach of the encyclopedia with its fuller interest, illustrations and references that we require. However, this cannot be put to the test as however much its need, we have no medical encyclopedia of this type. "Dorland's Dictionary" owes its enormous popularity because it is one of the few enterprises of this kind; it may be more the lack of competition than the qualities of usefulness and accuracy that have earned it the prominent position it now occupies!

"Dorland's" is an unmistakable American production. The binding is more slick than serviceable. The preface is obscured by "blurb" about "motivation of existence," "complete coverage" and "semicentennial" celebrations. The impressive list of contributors is very American, as is the text, e.g., "*œsophagus, see esophagus.*" I looked up toothless, half-hoping to find "edentulous incompensated." The biographical entries are so brief as to be valueless, the selection seems strange and biased. Harvey is casually mentioned under the adjectival *harvcian* (with a small h). Pott is dismissed with a terseness characteristic of himself, and of St. Vitus I could discover no mention.

The Editor has applied the principle—the more obscure the word the greater its call for inclusion—with vigour. With the rapidly growing medical vocabulary, and his wish to keep the dictionary in its present handy form, he is left with only two courses of action, either fewer or shorter entries. He has chosen, wrongly I think, the latter. Wrongly, when so much can be done about the former. Let me make this clear. As long as room can be found for entries such as *strainer, an apparatus for straining, and static, not dynamic*, there is no excuse for the extreme briefness in other entries. Bearing in mind that the type of person who is to use this book has had an extensive education and should possess an English dictionary to look up such words, many of these non-technical words (which, like the medical ones, are often inadequately defined and discussed) could be omitted. The selectors seem to have fared better amongst botanical and veterinary terms, which are adequately covered. In the fuller discussion of words, I should like to suggest some indications on the use of words: *Megaloscope, a large magnifying lens*, is an entry of no particular merit, and calculated to encourage the use of this cumbrous word. How much more useful to suggest as an alternative—magnifying glass. Similarly, no indication is made under acidophil that this is a hybrid word and undesirable, and that oxyphil should be used. This brings me on to the etymologists and consultant classicists, mentioned on one of the fly-leaves, who do not seem to have been looking to their jobs. The derivation of calix and calyx is confused, in fact, both are alleged to be indentical and referred to under calyx. Calix—icis, m. a cup or goblet (hence the English chalice) thus calic, plural calices, describes the subdivisions of the renal pelvis. Calyx—ycis, a whorl or flower bud, thus calyx, plural calyces, describes the whorl of the flower. Why no mention of the Medusa's Head? *Lesbianism, homosexuality between women*, seems a bizarre contradiction. To read from Intra-abdominal to Intravesical (five columns) is about as absorbing as a column of the S-Z telephone directory.

When a twenty-third edition of this remarkably popular book is issued, may I suggest: a stouter binding, the complete omission of the preface of publisher's "blurb," and the removal of the "Essay on the Fundamentals of Medical Etymology," which seemed to me to be not a "good foundation for the comprehension of the derivation and meaning of medical terms" but a cumbrous bore. Remove totally the Index to plates and tables, which are to be found more quickly by searching directly than by the cross reference. Then perhaps we may have room enough for fuller biographical entries, some of the old plates, references for further reading, and space to cope with the increasing hordes of words.

"Dorland's Dictionary" is a book that you want to buy the same day that you decide to be a doctor; it is a book you will use as a student, and least when you think you can most afford a copy. Congratulations on its "semicentennial." It is just reaching maturity; long may it continue. It is exceedingly reasonable in price (it may be mentioned here that Saunders have not raised their prices since the devaluation of the pound, despite the unfavourable exchange). It is on the whole accurate, though it is beginning to suffer from a natural complacency springing from a lack of competition. I may have seemed to deal a little harshly with this dictionary, but no words of mine could shake its enormous sale. At any rate, it is large enough not to mind, and I am too small for it to pay any attention.

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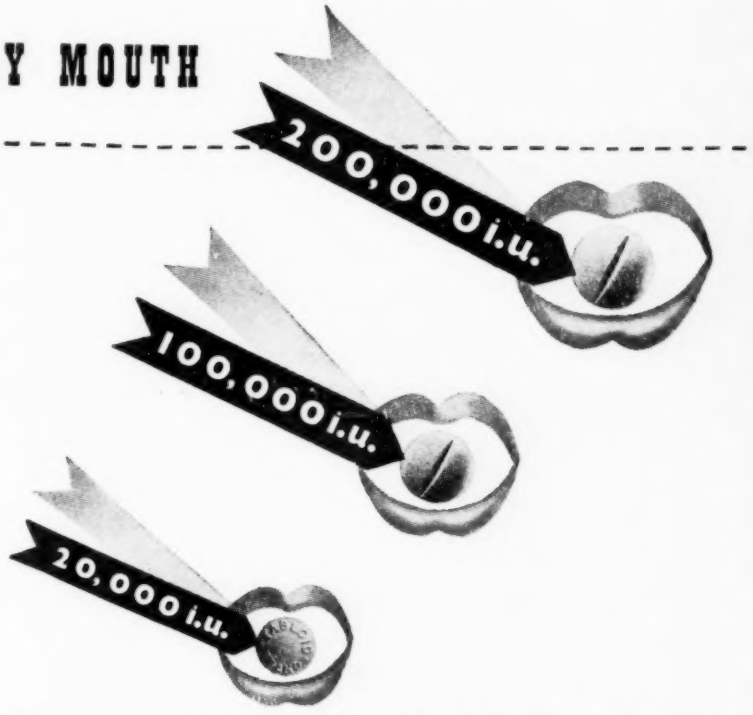

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